

**MATERNAL-FETAL MEDICINE RX ENROLLMENT FORM**

**PATIENT INFORMATION**

Patient Name: _____		Date of Birth: _____	Gender: _____
Home Phone: _____	Cell Phone: _____	Email: _____	
Address: _____	City: _____	State: _____	Zip: _____
Emergency Contact: _____		Emergency Phone: _____	

**CLINICAL INFORMATION**

Patient Weight: \_\_\_\_\_  kg  lbs  
 Patient Height: \_\_\_\_\_  cm  in  
 Allergies: \_\_\_\_\_  
 Current Gestational Age: \_\_\_\_\_ EDC: \_\_\_\_\_  
 Gravida: \_\_\_\_\_ Para: \_\_\_\_\_  
 Has patient previously received IG?  Yes  No  
 Pharmacy to coordinate home health nursing visit and/or nursing training

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_  
 DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_

**PRESCRIPTION INFORMATION** Pharmacy to select IG if medication left blank

**MEDICATION**  Pharmacy to select IG  Brand \_\_\_\_\_

**Dose and Directions**  
 Infusion Start Date: \_\_\_\_\_  
 Infuse \_\_\_\_\_ GRAMS IV daily for \_\_\_\_\_ day(s),  
 every \_\_\_\_\_ week(s) x \_\_\_\_\_ cycles  
 Other \_\_\_\_\_  
 +/- 4 days to allow scheduling flexibility  OK to round to the nearest vial size  
 Multiple doses will be administered on consecutive days unless ordered otherwise.  
 Rate protocol: Titrate initial and maintenance infusions per manufacturer's product labeling.

**DIAGNOSIS**

D69.3 Immune Thrombocytopenic Purpura (ITP)  
 Platelet Count: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 P78.84 Gestational Alloimmune Liver Disease (GALD)  
 O36.191 Maternal care for other isoimmunization, 1st trimester  
 P61.0 Transient Neonatal Thrombocytopenia (NAIT)  
 Has HPA-1a testing been completed?  Yes  No  
 Results Confirm NAIT:  Yes  No  
 Other \_\_\_\_\_

**REQUIRED FOR HOME INFUSION** RX to include diluents, needles, syringes, ancillary supplies, home medical equipment to administer infusion.

<b>IV Access</b>	<b>To be administered PERIPHERALLY, unless otherwise indicated.</b> <input type="checkbox"/> PORT <input type="checkbox"/> PICC
<b>Flush Protocol</b> for IVIG drug admin days only	<ul style="list-style-type: none"> <li>0.9% NaCl: 1-10mL IV before/after infusion, or PRN for line patency/SASH.</li> <li>Heparin 10 units/mL: 5mL IV (peripheral) PRN for final flush. *For multi-day infusions</li> <li>Heparin 100 units/mL: 5mL IV (central) PRN for final flush.</li> </ul> <p>* For multi-day infusions, peripheral IV to be obtained, maintained, and discontinued for the duration of the infusion cycle per RN discretion in accordance with INS guidelines.</p>
<b>Pre and Post Medications</b> Please strikethrough if not required	<b>To be given by mouth 30 minutes prior to infusion. May repeat every 4-6 hours as needed.</b>
	<b>Diphenhydramine</b> 25mg-50mg Adult max: 100mg/day
	<b>Acetaminophen</b> 325mg-650mg Adult max: 3000mg/day
<b>Anaphylaxis Protocol</b>	<b>To be given intramuscularly PRN severe allergic reaction. Call 911. May repeat x 1.</b> <ul style="list-style-type: none"> <li>Epinephrine 0.3mg (≥30kg/66lbs)</li> </ul>
<b>Hydration</b> Please select only if needed for IVIG	<input type="checkbox"/> 0.9% NaCl _____ mL infused over _____ minutes <input type="checkbox"/> D5W _____ mL infused over _____ minutes Nurse to determine hydration rate if rate not provided above.
	<b>To be infused pre-infusion, unless otherwise indicated.</b> <input type="checkbox"/> Concurrent with Infusion <input type="checkbox"/> Other _____
<b>Diphenhydramine</b> Please select only if needed for IVIG	<b>To be given via slow IV push PRN for moderate – severe reaction.</b> <input type="checkbox"/> 25-50mg <input type="checkbox"/> Other _____
<b>Quantity and Refills</b>	Dispense 1-month supply. Refills: _____
<b>Additional Orders</b>	

**PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)**

By signing this form and using this pharmacy's services, you are authorizing this pharmacy to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

<input type="checkbox"/> May Substitute/Product Selection Permitted/Substitution Permissible	<input type="checkbox"/> Dispense as Written/Brand Medically Necessary/Do Not Substitute/No Substitution/May Not Substitute
<b>Prescriber Signature</b> _____	<b>Prescriber Signature</b> _____
<b>Date</b> _____	<b>Date</b> _____

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" NY & Iowa providers, please submit electronic prescription.

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